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ABSTRACT

Three psychologists participated in an examination of the consistency and accuracy of subjective diagnoses of 20 institutionalized mentally retarded young adults and adults. The psychologists' informal ratings of the Ss' degree of retardation (mild, moderate, severe, profound) were correlated with one another and with the retardation levels as determined by the administration of the Broome Functional Behavior Checklist by direct care staff on the wards. Results indicated that the ratings of the psychologists were similar to one another (average correlation .84), but their ratings were much less in agreement with the checklist than with themselves. The psychologists tended to see the population as equally represented by each category of retardation, perhaps matching some internal expectation. Findings suggested that the psychologists were able to use subjective criteria to differentiate among gross differences in retarded individuals, but were unable to diagnose retarded individuals as accurately as the objective checklist. (CL)

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New York State Department of
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Technical Report 79-07

THE USE OF CLINICAL IMPRESSION IN DIAGNOSIS

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Clinical staff who work with the mentally retarded acquire an informal impression of their clients' skills and behavioral characteristics. This acquired information in turn is useful when working with unfamiliar clients for it enables the professional to make probabilistic statements on their clients' level of function, their ability to acquire new skills and their response to various treatment techniques. Such cognitive and prejudicial processes are referred to as clinical impressions.

In the past, some professionals have in fact relied upon these impressions to diagnose the retardation level in the absence of standardized testing instruments or functional profiles. Subjective diagnoses are found in the case records of several institutionalized clients and often were made by non-psychologists. This practice had led to multiple diagnoses not all of which proved to be correct.

The purpose of this study is to test the consistency and accuracy of subjective diagnoses. Professional staff will be asked to cognitively diagnose several retarded individuals and their impressions will be compared to each others' and to the diagnoses obtained from an objective instrument.

METHOD

CLINICAL STAFF - Three psychologists who worked in an upstate residential facility for the mentally retarded volunteered to participate in this study. Each of the psychologists had two years full-time, paid experience working with the retarded; however, all three of the psychologists had been working with the retarded in one capacity or another for an additional year. This experience included direct hands-on therapy with clients, supervision of treatment plans implemented by

ward staff, intellectual and adaptive behavior assessment, participation in resident case conferences, and serving as consultants to various facility programs and community agencies.

SUBJECTS - Twenty-four residents were selected from the same facility as the psychologists. There were seventeen males and seven females ranging in age from seventeen to fifty-two years of age.

In order to increase the likelihood that each of the three psychologists would have had an opportunity to become familiar with them, subjects who were residing in the facility for at least one year were selected. These subjects functioned at a variety of skill levels and had varying degrees of physical handicaps.

FUNCTIONAL SCALE - Information was collected on the adaptive behaviors for each of the subjects. The Broome Functional Behavior Checklist (Grosek, 1979) was employed for this purpose. This checklist was derived from Grossman's (1977) guideline for evaluating and diagnosing the adaptive behavior of retarded individuals. The checklist addresses seven principle domains including self-help skills, physical skills, language, social skills, economic skills, occupational skills and self-direction. Each of these domains were further subdivided into sub-categories and, where applicable, sub-category items were arranged into a hierarchy. In all, the checklist contained one-hundred and twelve items. The checklist yields a total score which in turn can be translated into a level of retardation.

On the ward, the checklist was distributed to direct care staff who most frequently worked with each subject. The staff were instructed in the use

of the scale and were asked to indicate if each skill was present or absent.

PROCEDURE - The psychologists were asked to rate the degree of retardation (mild, moderate, severe, profound) for each of the subjects. They were instructed that they could use any subjective criteria for making this diagnosis, however they were not to use or refer to any standardized instrument, nor were they to refer to the subject's record. In essence, they were asked to give their clinical impression on each of the subject's retardation level.

The psychologists' ratings were correlated with one another and with the retardation levels as determined by the functional checklist.

RESULTS

Two psychologists did not feel that they were sufficiently familiar with some of the clients to make a diagnosis, and accordingly, four subjects were dropped from the study.

Table I presents the ratings of each of the psychologists and of the functional profile. The first three columns reflect the ratings of each psychologist and is followed by a combined overall rating in column four. This rating represents the majority rating of each of the three psychologists. The last column indicates the level of retardation as determined by the behavioral checklist.

The level of retardation ratings given to the clients by each psychologist were correlated with one another and are presented below:

R1: $r_{1,2} = .88$

$r_{2,3} = .94$

$r_{3,1} = .80$

Using a Z-transformation, an average correlation was calculated for these three scores:

R2: r Average = .89

Next, the psychologists' retardation levels were correlated with the retardation levels as determined by the Broome Functional Behavior Checklist.

R3: $r_{1,c} = .80$

$r_{2,c} = .81$

$r_{3,c} = .73$

Using the Z-score transformation, the average correlation of the psychologists' ratings with the checklist was correlated.

R4: r checklist Average = .78

Table II indicates the number of subjects in each category of retardation as predicted by both the psychologists' ratings and by the Functional Behavior Checklist. For the psychologists' ratings, at least two psychologists agreed on the level of retardation for each client, and that was the level of retardation that was used in the table. Here we may note that the psychologists divided their ratings among the twenty clients fairly evenly over the four categories, whereas the checklist tended to place proportionately more clients in the profound and severe categories.

DISCUSSION

The ratings by the three psychologists were similar to one another as evidenced by the high average correlation of .89. This perhaps is not unusual, for the three individuals worked in the same facility with similar clients and frequently share views and philosophies with one another. On the other hand, line R4 and Table II reflected that

the psychologists' ratings were much less in agreement with the checklist than with themselves. Table II indicates that the psychologists tended to see the population of clients as being equally represented by each category of retardation. One would suspect that this equal ordering of subjects matched some internal expectation. Since there were four possible categories of retardation, one might imagine that the population under observation should, or must be represented equally in each category.

The ratings by the objective checklists quickly dispels this notion. Proportionately, more subjects (70% of the total) fell into the profound and severe levels of retardation. Although a subject pool of twenty is a small sample, this data suggests that the subjects were not equally divided among all levels of retardation. In theory, also, one would not expect to find an equal division of subjects. With support services available, the community is capable of maintaining retarded individuals in family and group homes, and in many cases, retarded individuals live by themselves. The clients most eligible for community placement are high functioning individuals who have self-help skills as well as language abilities. These are the mildly and moderately retarded. Thus, even though there are proportionately more mildly retarded individuals in the U.S. population (Ingalls, 1978), few of them are actually institutionalized. These clinical diagnoses may have also been biased by insufficient observation of client behavior as well as by the halo effect of overestimating the abilities of familiar clients.

The moderate correlation .78 between the psychologists' clinical impressions and the more objective checklist ratings suggests that the two systems rank-ordered the subjects in a similar fashion. This lower correlation occurred when the checklist labeled some of the subjects

that the psychologists called "mild" as being "moderates", some "moderates" as "severe", and some "severe" as "profound". Although the ratings are lower, the general rank-ordering is preserved. In fact, the Spearman rank correlation coefficient between the two sets of data (columns 4 and 5 in Table I) is .98.

In general, it appears that the psychologists were able to use subjective criteria to differentiate among gross differences in retarded individuals, but they were unable to diagnose retarded individuals as accurately as the objective checklist. Fortunately, more and more clinicians are abandoning the concept of diagnostic labels in general, for they are not meaningful either for treatment prescription, or for treatment prognosis. The inutility of the psychologists' subjective impression in this area, however, does not necessarily generalize to other decisions that they must make in terms of choice of treatment techniques or reinforcement regimes. In these areas, they too must use their clinical judgement in order to treat the client, but there is no reason to believe that their decision process is as faulty here as it is with the diagnoses. This would be an independent area of study.

BG:sl

9/11/79

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TABLE I

Retardation Levels as Determined by
Psychologists Ratings and by Broome Functional Behavior Checklist

Subject	Psychologist Ratings				Behavior Checklist
	1	2	3	Overall	
1	Mo*	Mi	Mi	Mi	Mo
2	Mo	Mi	Mi	Mi	S
3	Mi	Mi	Mi	Mi	Mi
4	Mi	Mi	Mi	Mi	Mi
5	Mi	Mi	Mi	Mi	S
6	Mi	Mi	Mi	Mi	S
7	Mi	Mi	Mi	Mi	Mi
8	Mo	Mo	Mo	Mo	S
9	Mo	Mo	Mo	Mo	Mo
10	Mo	Mo	S	Mo	S
11	Mo	Mo	Mi	Mo	S
12	Mo	Mo	Mo	Mo	S
13	S	S	S	S	P
14	Mo	S	S	S	P
15	S	S	S	S	P
16	S	S	S	S	P
17	S	S	Mo	S	P
18	S	P	P	P	P
19	S	P	P	P	P
20	S	P	P	P	P

Mi = Mild Mo = Moderate S = Severe P = Profound

TABLE II

Distribution of Ratings by Psychologist
and by Checklist

Level of Retardation	Psychologists' Ratings	Checklists Ratings
Profound	3 (15%)	8 (40%)
Severe	5 (25%)	6 (30%)
Moderate	5 (25%)	3 (15%)
Mild	7 (35%)	3 (15%)